New Patient Registration Form

Today's Date_____

Last Name_____ First Name_____ Date of Birth_____

Nickname_____ ☐Male ☐Female

Parent/Guardian Name_____ DOB_____/_____/_____

Address_____City_____State_____ZIP_____

Home ph_____cell ph_____ work ph_____

Email_____ Employer_____

Parent/Guardian Name_____ DOB_____/_____/_____

Address_____City_____State_____ZIP_____

Home ph_____cell ph_____ work ph_____

Email_____ Employer_____

Who does patient live with? MOTHER FATHER BOTH GUARDIAN

NOTE: If parents are divorced or living separately, please provide copies of custody papers at FIRST visit

Primary Insurance Company _____ID number _____Group Number_____

Insurance phone number _____

Subscriber's name_____ Subscriber's DOB_____/_____/_____

Subscriber's relationship to patient_____

Secondary Insurance Company_____ ID number _____Group Number_____

Insurance phone number _____

Subscriber's name_____ Subscriber's DOB_____/_____/_____

Subscriber's relationship to patient_____

Preferred Pharmacy_____ **Pharmacy phone number**_____

Medicaid Waiver

Continuum Pediatrics will NOT ACCEPT Medicaid of Texas as primary or secondary insurance.

I _____ (patient's guardian) have read, understand, and agree to the above policy by Continuum Pediatrics. I will be responsible for any non-covered services not covered by my health insurance plan(s).

This waiver is valid for all dates of service. All patients must complete & sign this form even if you have no intention of using Medicaid as a form of payment.

_____ _____ _____

Parent/Guardian's Signature Relationship to Patient Date

Consent for Treatment Authorization

Patient Name _____ Date of Birth _____

Parent/Guardian's Printed name _____

I hereby authorize the following person(s) to seek medical care and make decision in relation to advice rendered at Continuum Pediatrics and/or its employees in my absence:

_____	_____	_____	_____
Printed Name	Relationship to Patient	Printed Name	Relationship to Patient
_____	_____	_____	_____
Printed Name	Relationship to Patient	Printed Name	Relationship to Patient

This authorization shall remain in effect from today's date for a period of one year, sooner if revoked in writing or if any changes.

Assignment of Benefits

Financial responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our billing office. Necessary forms will be completed to file for insurance carrier payments.

If the child has multiple carriers it is solely the parent/guardian's responsibility to inform this office. Should any claims be denied of payment for this reason and our office has not been aware, payment of all denied claims will become the responsibility of the parent/guardian.

There may be times when a "well" visit will be changed to a "sick" visit based on diagnosis during your evaluation by the physician. Your insurance company may require you to pay additional coinsurance or fees at the time of service. Please check with your insurance carrier about your specific benefits.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier to issue payment checks directly to Continuum Pediatrics, a division of Texas Digestive Disease Consultants- GI Alliance, for medical services rendered to myself and or my dependents regardless of my insurance benefits, if any. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY THE INSURANCE.

Authorization to release information

I hereby authorize Continuum Pediatrics to 1) release any information necessary to insurance carriers regarding my illness and treatments (2) process insurance claims generated in the course of examination and treatments; (3) allow a photocopy of my signature to be used in the process of insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from on behalf of myself and or my dependents, and I understand that by making this request, I BECOME FULLY FINANCIALLY REPONSIBLE FOR ANY AND ALL CHARGES INCURRED IN THE COURSE OF THE TREATMENT AUTHORIZED.

I FURTHER UNDERSTAND THAT FEES ARE DUE AND PAYABLE AT THE TIME THAT SERVICES ARE RENDERED, AND I AGREE TO PAY ALL SUCH CHARGES INCURRED IN FULL IMMEDIATELY UPON PRESENTATION OF THE APPROPRIATE STATEMENT. A photocopy of this assignment is to be considered as valid as the original.

_____

Parent/Guardian's Signature

_____ _____

Relationship to Patient Date

Office Policies

Vaccine Policy:

_____I have read the enclosed vaccine policy and intend to vaccinate my child according to the most current guidelines set forth by the American Academy of Pediatrics and the US Centers for Disease Control.

After Hour Calls:

_____Our office hours are Monday through Friday 8:00am to 5:00pm. We make every effort to return patient calls promptly, usually by the end of the business day. After hour calls are defined as calls received after 5:00pm Monday-Friday and all weekends or holidays. These calls will accrue a **$35.00** ***after hours call fee*** applied to your account. This fee cannot be billed to your insurance company.

No Show Policy:

_____We ask you to be considerate of the medical needs of others and call our office promptly within 24 hours of your appointment if you are unable to make your appointment time. This allows us to make your appointment available to another patient who needs medical attention.

If you do not arrive for your appointment, or fail to cancel prior to 24 hours before your appointment time, there will be a **$50.00** ***no show fee*** applied to your account that will need to be paid in full by the next scheduled appointment time. This fee cannot be billed to your insurance company.

You may be reminded of your upcoming appointment by portal reminder, text, or phone call. Please understand that these reminders regarding your appointment are a COURTESY only, any disputes regarding no shows because of a courtesy call or text "not received" will NOT be waived. You are ultimately responsible.

The doctors make every effort to be respectful of our patients' time and to see our patients on time. Please be aware that if you arrive **10 minutes** after your scheduled appointment time, you may be asked to reschedule.

Letters/Completion of Forms:

_____Please bring any forms that require a doctor's approval to your appointment. Any requests for forms to be completed after an appointment will accrue a fee. This fee will be applied to your account and will not be covered by insurance. Please give our office 48 hours to complete any forms. Any letter that you request the physician to write also will incur a fee. This fee cannot be billed to your insurance company. Please contact the office staff for a list of fees for commonly requested forms.

Consent for Photography:

_____I hereby consent Continuum Pediatrics to photograph my child and an adult caregiver. The purpose is to document the identity of the patient and caregiver in the medical and billing records for the purpose of clinical care as well as collection of payments.

_____ _____

Patient's Name (PRINT) Date

_____ _____

Parent's Name (PRINT) Parent/Guardian's Signature

Authorization to Use and Disclose Protected Health Information

Patient Name: _____ Birth Date: _____/_____/____

I authorize Continuum Pediatrics d/b/a GI Alliance on behalf of itself and all other practices that are operating as a single HIPAA Affiliated Covered Entity (collectively "Provider") to use and disclose the information described below to the following recipient(s):

_____.

This authorization applies to the following types of information (*check one*):

[ ] all information about Patient held by Provider including full copies of medical records, which will include but not be limited to, diagnosis information, records of treatment received, laboratory test results, and appointment records.

[ ] **only** the following information (*check applicable boxes/ fill out description*):

[ ] medical records for Patient from _____ date through _____ date.
[ ] other: _____.

If initialed below, Provider is authorized to include the following types of information if they are included in the records I have authorized to be disclosed:

____ HIV/AIDS-related information (including test results)
____ Mental health information (except psychotherapy notes)
____ Drug, alcohol or substance use disorder information
____ Genetic information (including genetic test results)

The purpose of this authorization is (*check one*)
[ ] at Patient's request [ ] Other (*please specify*) _____.

This authorization will be effective for one (1) year from the date signed below or the date on which Patient no longer receives services from Provider, whichever is later. I have the right to revoke this authorization at any time by notifying Provider at Continuum Pediatrics, 9509 N. Beach St.,#102, Fort Worth, TX 76244; Attn: Privacy Officer. My revocation must be in writing. My revocation will not be effective to the extent Provider has already relied upon this authorization (by using or disclosing information).

Signing this form is optional. Provider will not condition Patient's treatment or payment for care on whether I sign this form. Once information is disclosed as a result of this form, it may no longer be protected by the federal HIPAA privacy rules. I may obtain a copy of this form by contacting the Privacy Officer at the address listed above.

_____ _____/_____/_____
Signature of Patient or Patient's Representative Date

If signed by the Patient's representative, complete the following:
Printed Name of Personal Representative: _____
Authority of Personal Representative (*e.g.,* health care power of attorney, guardian, parent):

_____

Uses and Disclosures of PHI and Methods of Communication

1. ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Continuum Pediatrics ("Practice") HIPAA Notice of Privacy Practices. By signing below, I consent to the uses and disclosures described under the heading: "**Uses and Disclosure of PHI that Do Not Require an Authorization**." Other uses and disclosures will require a separately signed authorization unless otherwise permitted by law. If I have a question or complaint, I understand that I may contact the Practice by phone at 1-877-373-1630 or by email at complianceGIA@gialliance.com.

2. DISCLOSURES TO FRIENDS AND/OR FAMILY MEMBERS

If you would like the Practice to share protected health information about your care with your friends or family members, please list the individual(s) who may receive your information below.

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

3. TEXTS and EMAILS

Please check all that apply to you:

I consent to receive text messages and/or calls from Practice (or its vendors), including calls and messages using automated dialing technology, at the cell phone number on file with Practice.

I consent to receive emails from Practice (or its vendors) at the email address on file with Practice.

Calls, text and/or emails from Practice may include information relating to my healthcare services, financial obligations, appointment reminders, referrals, prescription information, or promotional or other marketing offers and services from Practice. I understand that these messages are unencrypted and there is risk that information included in the messages may be intercepted by unintended third parties and/or stored by our service providers and system operators. My consent is not a condition to receive services and message and data rates may apply. To stop receiving text messages, I may opt-out by texting STOP. To stop receiving email messages, I may opt-out by unsubscribing.

By signing below, I agree to each of the above items (Section 1, Section 2 and each marked sentence of Section 3).

_____

Signature Date

_____

Printed Name of Patient

If signed by patient's representative, description of authority (such as parent/guardian):

_____

FOR OFFICE USE ONLY
IF THE PATIENT DOES NOT ACKNOWLEDGE THE NOTICE

The Practice has made a good-faith effort to obtain an acknowledgment of _____ (patient's name) receipt of our Notice of Privacy Practices. The Practice has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

- ☐ Patient Unavailable
- ☐ Patient Physically Unable
- ☐ Patient Unwilling
- ☐ Other _____

In an effort to obtain the patient's acknowledgment, the Practice has attempted to provide the patient with the Notice in the following manner (check all that apply):

☐ Personally ☐ Mail ☐ E-mail ☐ Other_____

_____

Signature Date

_____

Printed Name of Practice Representative

TEXAS Health and Human Services | Texas Department of State Health Services

IMMUNIZATION REGISTRY (ImmTrac2)
Minor Consent Form

(Please print clearly)

Child's Last Name

Child's First Name **Child's Middle Name**

Child's Date of Birth *Children younger than 18 years old only. **Child's Gender:** ☐ **Male** ☐ **Female**

Child's Address **Apartment #** **Telephone**

City **State** **Zip Code** **County**

Mother's First Name **Mother's Maiden Name**

ImmTrac2, the Texas immunization registry, is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your child's (younger than 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac2. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry.

Consent for Registration of Child and Release of Immunization Records to Authorized Entities

I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac Group – MC 1946, P.O. Box 149347, Austin, Texas 78714-9347.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my child's information in the Texas immunization registry.

Parent, legal guardian, or managing conservator:

Printed Name

Date

Signature

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com

Texas Department of State Health Services • ImmTrac Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

continuum PEDIATRICS

New Patient Health History

Name_____ Date of Birth _____

Birth History

Was your child born ☐ full term ☐ early

What was your child's weight at birth? _____Any problems after birth? _____

Was your child delivered ☐ by C-section ☐ vaginally

Does your child have any chronic medical problems?

_____

Does your child take any medications on a regular basis? If so, please list below.

_____

Does your child have any allergies to medications?

_____

Has your child ever been hospitalized overnight? (not ER visits)

_____

Has your child ever had any surgeries? If so, please list below.

_____

Tell us about your family:
Patient's Mother: age _____ medical problems _____
Patient's Father: age _____ medical problems _____
Patient's Brother(s): age _____ medical problems _____
Patient's Sister(s): age _____ medical problems _____

Do you have any forms that you would like the doctor to complete? _____YES _____NO

Do you have any concerns you would like to discuss with the doctor today?

_____

Informed Consent for Telemedicine Medical Services

1. Introduction: Please read this document thoroughly and completely. To better serve the needs of the community, especially in light of the Coronavirus pandemic, health care services are now available using telecommunications or information technology ("Telemedicine"). Telemedicine involves the use of real-time evaluation, diagnosis, consultation, and treatment of health conditions using interactive telecommunications technology allowing the health care provider to see and communicate with you in real-time.
2. Consent for Treatment: You have voluntarily requested that a health care provider of GI Alliance participate in your medical care through the use of Telemedicine. In doing so, you understand, acknowledge and agree to the following:
   a. The health care provider may practice in a location different than where you normally go to receive in-person medical care.
   b. Unlike traditional medicine, the health care provider providing the Telemedicine services will not have the opportunity to meet with you face to face.
   c. The health care provider providing the Telemedicine services must rely on the information you provide.
   d. To the best of your ability, you agree to provide complete and accurate information concerning your medical history, condition and care as may be requested by the health care provider.
   e. You understand that if the health care provider feels that your medical needs cannot be adequately addressed using Telemedicine, you may be required to seek an in-person evaluation.
   f. You understand you can stop your Telemedicine session at any time.
   g. You understand you can ask questions or seek clarifications of the Telemedicine procedures and technology at any time.
   h. You understand that no guarantee of any specific result or cure is made by the health care provider rendering the Telemedicine services.
   i. If you experience an emergency after the Telemedicine session, you should alert your primary treating physician and dial 911 or go to the nearest emergency department.
3. Risks. You agree and acknowledge that there are potential risks associated with receiving medical care using Telemedicine:
   a. The Telemedicine session may be interrupted or disconnected due to a technological problem or equipment failure.
   b. There may be electronic tampering.
   c. The advice provided by the health care provider may be based on factors not within his/her control, such as incomplete or inaccurate information provided by you or distortions of diagnostic images or specimens due to their electronic transmission.
4. NOTICE CONCERNING COMPLAINTS. While we hope all patients are happy with the Telemedicine services they receive, you have a right to make a verbal or written complaint. If you have comments, questions or concerns, please contact us. Telemedicine Consent Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation to the following address:

   Texas Medical Board
   Attn: Investigations
   333 Guadalupe, Tower 3, Suite 610
   P.O. Box 2018, MC-263
   Austin, TX 78768-2018

Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353. For more information on filing a complaint with the Texas Medical Board, visit the Texas Medical Board website at www.tmb.tx.us

Patient or Guardian Signature: _____

Name (printed): _____ Date: _____

Medical Record Release

To whom it may concern:
I hereby authorize the release of my child(ren)'s medical records, or copies of such, and request that they be transferred from your office to **Continuum Pediatrics**, as soon as possible.

From:

Office Name _____

Address _____

City _____ State_____ ZIP_____

Phone _____ Fax _____

To: Kathryn K. Mandal, MD, FAAP
Krystyna Wesp, DO, FAAP
Likhitha Reddy, MD
Cynthia Giovannetti, MD

Continuum Pediatrics

9509 N. Beach St, Suite 102
Fort Worth, TX 76244
ph. 817.617.8600
fax 1.877.906.1852
email: frontdesk@continuumtx.com

NO DISKS/CD's PLEASE!!

Check the records to be disclosed:

☐ Immunizations ☐ Growth Charts Other: _____

Below are my child(ren)'s names and date(s) of birth:

Name_____ Date of Birth____/_____/_____

Name_____ Date of Birth____/_____/_____

Name_____ Date of Birth____/_____/_____

Name_____ Date of Birth____/_____/_____

I understand that these records may contain details regarding psychiatric illness, drug or alcohol treatment, HIV/AIDS testing and status, sexually transmitted disease diagnosis and other sensitive medical information of either my children, myself, or my child's other parent.

Parent's name_____ Relationship to patient_____

Parent's Signature_____ Date_____

Contact phone number _____

Thanks for coming! How did you hear about us?

☐Former, Current, or sibling's patient of office

☐Facebook post

☐Internet search

☐Heard about her from a friend _____

☐Postcard mailed to your home

☐Another doctor referred you _____

☐Attended a community event _____

☐Other _____

Vaccine Policy

◆ We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

◆ We firmly believe in the safety of our vaccines.

◆ We firmly believe that all children and young adults should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.

◆ We firmly believe, based on all available literature, evidence, and current studies, that vaccines DO NOT cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in some vaccines, does not cause autism or other developmental disabilities.

◆ We firmly believe that vaccinating children and young adults may be the single most important health-promoting intervention we perform as health care providers, and that you can perform as parents/caregivers. The recommended vaccines and their schedule given are the results of years and years of scientific study and data gathering on millions of children by thousands of our brightest scientists and physicians.

These things being said, we recognize that there has always been and will likely always be controversy surrounding vaccination. Indeed, Benjamin Franklin, persuaded by his brother, was opposed to smallpox vaccine until scientific data convinced him otherwise. Tragically, he had delayed inoculating his favorite son Franky, who contracted smallpox and died at the age of 4, leaving Ben with a lifetime of guilt and remorse. Quoting Mr. Franklin's autobiography:

"In 1736, I lost one of my sons, a fine boy of four years old, by the smallpox . . . I long regretted bitterly, and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation, on the supposition that they should never forgive themselves if a child died under it, my example showing that the regret may be the same either way, and that, therefore, the safer should be chosen."

The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that we are even dis- cussing whether or not they should be given. Because of vaccines, many of you have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox, or known a friend or family member whose child died of one of these diseases. Such success can make us complacent or even lazy about vaccinating. But such an attitude, if it becomes widespread, can only lead to tragic results.

After publication of an unfounded accusation (later retracted) that MMR vaccine caused autism in 1998, many people in Europe chose not to vaccinate their children. As a result of under immunization, there were large outbreaks of measles, with several deaths from complications of the disease. In 2010 there were more than 3000 cases of whooping cough in California, with nine deaths in children less than six months of age. Again, many of those who contracted the illness (and then passed it on to the infants, who were too young to have been fully vaccinated) had made a conscious decision not to vaccinate.

Furthermore, by not vaccinating your child you are taking selfish advantage of thousands of others who do vaccinate their children, which decreases the likelihood that your child will contract one of these diseases. We feel such an attitude to be self-centered and unacceptable.

We are making you aware of these facts not to scare you or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to convince you that vaccinating according to the schedule is the right thing to do. However, should you have doubts, please discuss these with our office in advance of your visit. **Please be advised, that delaying or "breaking up the vaccines" to give one or two at a time over two or more visits goes against expert recommendations, and can put your child at risk for serious illness (or even death) and goes against our medical advice as providers at Continuum Pediatrics.**

All patients in the practice are required to receive a minimum of DTaP, Hib, polio, and pneumococcal vaccines by three months of age, all AAP-recommended immunizations by two years of age, and meningococcal vaccine and booster doses of Tdap and varicella vaccines by age 12 years.

Finally, if you should absolutely refuse to vaccinate according to the CDC and AAP guidelines, despite all our efforts, we will ask you to find another health care provider who shares your views. We do not keep a list of such providers, nor would we recommend any such physician. Please recognize that by not vaccinating you are putting your child at unnecessary risk for life-threatening illness and disability, and even death.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults.

Thank you for your time in reading this policy, and please feel free to discuss any questions or concerns you may have about vaccines with any one of us.

From Drs. Kathryn Mandal, Krystyna Wesp, Likhitha Reddy, Cynthia Giovannetti, and the Staff of Continuum Pediatrics.

HIPAA NOTICE OF PRIVACY PRACTICES

Effective March 1, 2023

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Scope of Notice
This Notice of Privacy Practices ("Notice") applies to all protected health information ("PHI") about you held or transmitted by Continuum Pediatrics,Texas Digestive Disease Consultants, PLLC d/b/a GI Alliance and each of its subsidiaries and affiliates who are under common control and/or common ownership that are subject to HIPAA (as defined below) and are designated for HIPAA purposes as an affiliated covered entity (collectively, "we" or "our Practice").

PHI is any individually identifiable health information about your past, present or future physical or mental health or condition, the provision of healthcare to you, or your payment for healthcare. PHI may include information about your condition or treatment, diagnostic tests and images, and related health information.

Our Responsibilities
Our Practice is dedicated to maintaining the privacy of your PHI. Our Practice is required by the Health Insurance Portability and Accountability Act ("HIPAA") to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to your PHI. We are also required by law to notify affected individuals following a breach of unsecured PHI.

Our Practice must abide by the terms of this Notice while it is in effect. This Notice will remain in effect until our Practice replaces it. We reserve the right to change the terms of this Notice at any time, provided the changes comply with applicable law. If our Practice changes the terms of this Notice, the new terms will apply to all PHI we maintain, including PHI that was created or received before such changes were made. If our Practice changes this Notice, we will post the new Notice on our website and will provide copies upon request.

Uses and Disclosure of PHI that Do Not Require an Authorization
The following categories describe the different ways that our Practice may use and disclose your PHI without your authorization. Not every use and disclosure within a category will be listed. Your PHI may be stored in paper, electronic or other form and may be disclosed electronically or by other methods.

Treatment. Our Practice may use and disclose your PHI for treatment purposes. For example, we may disclose PHI to another healthcare provider to whom we refer you. Moreover, we may use and disclose your PHI electronically, such as by providing you care via telehealth (which involves the use of electronic communications via live two-way audio or video) or by communicating with you through our patient portal (if you choose to access the portal).

Payment. Our Practice may use and disclose your PHI to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections and claims management. These activities also include determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, our Practice may send claims to your health insurance provider containing certain PHI.

Healthcare Operations. Our Practice may use and disclose your PHI for healthcare operations purposes. Healthcare operations include quality assessment and improvement activities, arranging for legal services, conducting training programs, reviewing the competence and qualifications of healthcare professionals, licensing activities, and sending you information about our health-related products and services, possible treatment options or alternatives that may interest you, or appointment reminders. We may make incidental disclosures of limited PHI, such as by mailing statements to you with your name on the envelope.

Business Associates. Our Practice may disclose your PHI to third parties who provide services to our Practice or on our Practice's behalf, known as Business Associates. Our Practice requires our Business Associates to enter an agreement to safeguard your PHI and otherwise protect your privacy as required by law.

Electronic Data Exchanges. Consistent with applicable law, we may send you text messages, emails or other electronic communications for treatment, payment, healthcare operations and other permitted purposes. Our Practice may participate in one or more Health Information Exchanges (HIEs) and may electronically share your PHI for treatment, payment, healthcare operations and other permitted purposes with other participants in the HIE. HIEs allow your healthcare providers to efficiently access and use your PHI as necessary for treatment and other lawful purposes.

Individuals Involved in Your Care or Payment for Your Care/Personal Representatives. Our Practice may disclose your PHI to your family or friends, or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, if a person has the authority by law to make healthcare decisions for you, we may disclose information about you to such patient representative and treat that patient representative the same way we would treat you with respect to your PHI. We may also disclose your PHI to a public or private entity authorized by law to assist in disaster relief efforts to notify, or assist in notifying, a

family member or personal representative about your location, general condition, or death.

Required by Law. Our Practice may use or disclose your PHI when we are required to do so by law. For example, we may disclose PHI about you to the U.S. Department of Health and Human Services if it requests such information to determine that we are complying with federal privacy law.

Public Health Activities. Our Practice may disclose your PHI to public health authorities or other governmental authorities for public health purposes including preventing and controlling disease, reporting child abuse or neglect and reporting to the Food and Drug Administration regarding the quality, safety and effectiveness of a regulated product or activity. Our Practice may, in certain circumstances, disclose PHI to persons who have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition as necessary in the conduct of a public health intervention or investigation.

Health Oversight Activities. Our Practice may disclose your PHI to a health oversight agency for authorized activities such as audits, investigations, inspections, licensing and disciplinary actions.

Abuse, Neglect or Domestic Violence. If our Practice reasonably believes you are a victim of abuse, neglect, or domestic violence, we may disclose your PHI to a government authority, including a social service protective agency, authorized by law to receive reports of abuse, neglect or domestic violence.

Judicial and Administrative Proceedings. Our Practice may disclose your PHI in response to an order from a court or administrative agency. We may also disclose your PHI in response to a subpoena, discovery request or other lawful process instituted by someone involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. Our Practice may disclose your PHI for law enforcement purposes as permitted by HIPAA.

Coroners, Medical Examiners and Funeral Directors. Our Practice may disclose your PHI to coroners, medical examiners and/or funeral directors for purposes such as identification, determining the cause of death, and fulfilling duties relating to deceased individuals.

Research. Our Practice may use or disclose your PHI for research when permitted by law, including when an institutional review board or privacy board has reviewed the research proposal and established a process to ensure the privacy of the requested information and approved the research.

Serious Threat to Health or Safety. Our Practice may use or disclose PHI when permitted by applicable law to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Worker's Compensation. Our Practice may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Specialized Government Functions. Our Practice may use and disclose PHI for specialized government functions, including military and veterans' activities, national security and intelligence activities, and to correctional institutions.

Organ Donation. Our Practice may use and disclose your PHI to entities involved in procuring, banking, and transplanting organs, eyes and tissues to assist with donation or transplantation.

Limited Data and De-identified Data. Our Practice may remove most information that identifies you from a set of data and use and disclose this data set for research, public health and healthcare operations, provided the recipients of the data set agree to keep it confidential. We may also de-identify your PHI and use and disclose the de-identified information for purposes permitted by law.

Use and Disclosure of PHI Pursuant to an Authorization

In any other situation not described in this Notice, our Practice will ask for your written authorization before using or disclosing information about you, in accordance with applicable law. Most uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI will be made only with your written authorization. You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI for the purpose previously authorized, except to the extent that we have already taken action in reliance on the authorization.

Your Rights Regarding Your PHI

You have the following rights regarding the PHI maintained by our Practice. If you have given another individual a medical power of attorney, if another individual is appointed as your legal guardian or if another individual is authorized by law to make healthcare decisions for you (such as your custodial parent) (known as a "personal representative"), that individual may exercise any of the rights listed below for you.

Confidential Communications. You have the right to receive confidential communications of your PHI. You may request that our Practice communicate with you through alternate means or at an alternate location, and our Practice will accommodate your reasonable requests. You must submit your request in writing to our Practice. If

we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

Restrictions. You have the right to request restrictions on certain uses and disclosures of PHI for treatment, payment or healthcare operations. You also have the right to request that our Practice restrict its disclosures of PHI to only certain individuals involved in your care or the payment of your care. You may also request to opt out of participation in HIEs. You must submit your request in writing to our Practice. Our Practice is not required to comply with your request, except we are required to agree if your request is to restrict disclosures to a health plan for purposes of carrying out payment or healthcare operations, and the information pertains solely to a healthcare item or service for which you, or a person on your behalf (other than the health plan), has paid us out-of-pocket in full. If our Practice agrees to comply with your request, we will be bound by such agreement, except when otherwise required by law or in the event of an emergency.

Access. You have the right to inspect and obtain copies of your PHI that we maintain and to direct us to send your PHI stored in an electronic record to another person designated by you, with limited exceptions. This right applies to PHI used to make decisions about you or payment for your care, subject to limited exceptions provided by law. You must submit your request in writing to our Practice using the information provided at the end of this Notice. In most cases, we will provide access to you or the person you designate to get access within 30 days of your request or, if applicable, any shorter time period required by law.

Our Practice may deny your request to inspect and/or obtain a copy of your PHI in certain limited circumstances, such as if we reasonably conclude that it would be detrimental to you. If we deny your request, we will inform you of the reason for the denial, and, in most cases, you may request a review of the denial. If you request PHI that we maintain on paper, we may provide photocopies. If you request PHI that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible.

We may impose a reasonable cost-based fee for the costs of copying, mailing, labor and supplies associated with your request.

Amendment. You have a right to request that our Practice amend your PHI if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is maintained by our Practice. You must submit your request in writing to our Practice using the information provided at the end of this Notice and provide a reason to support the requested amendment. Our Practice may, under certain circumstances, deny your request by sending you a written notice of denial. If our Practice denies your request, you will be permitted to submit a statement of disagreement for inclusion in your records.

Accounting of Disclosures. You have a right to receive an accounting of certain disclosures our Practice has made of your PHI. This right does not include disclosures made pursuant to an authorization and certain other disclosures. You must submit your request in writing to our Practice using the information provided at the end of this Notice, and you must specify the time period involved (which must be for a period of time less than six years from the date of your request). Your first accounting within a period of 12 months will be free of charge. However, our Practice may charge you a reasonable cost-based fee for the costs involved in fulfilling any additional request made within the same 12-month period. Our Practice will inform you of such costs in advance so that you may withdraw or modify your request to save costs.

Paper Copy of this Notice. You have the right to obtain a paper copy of this Notice from our Practice at any time upon request, even if you have agreed to receive this Notice electronically. To obtain a paper copy of this notice, please email complianceGIA@gialliance.com or ask for a copy at one of our offices.

Complaints

You may complain to our Practice and/or to the Secretary of the Department of Health and Human Services ("the Secretary") if you believe that your privacy rights have been violated. You may submit complaints to our Practice by contacting our Practice's Privacy Officer at complianceGIA@gialliance.com or by calling our Privacy Officer at 1-877-373-1630**.**

Our Practice will not retaliate against you if you file a complaint with our Privacy Officer or the Secretary. You may file a complaint with the Secretary by contacting:

U.S. Department of Health and
Human Services Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Phone: 1-877-696-6775; or
www.hhs.gov/ocr/privacy/hipaa/complaints/

Contact Information

For more information about your privacy rights, please contact our Privacy Officer at complianceGIA@gialliance.com or1-877-373-1630.